

U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 20 July 2005

CASE NO.: 2004-BLA-05635

In the Matter of

BRANSON COLEMAN
Claimant

v.

IKE COAL COMPANY, INC.
Employer

and

KY COAL PRODUCERS,
SELF-INSURANCE FUND
Carrier

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS
Party in Interest

Appearances:

Stephen A. Sanders, Esquire
For Claimant

David H. Neeley, Esquire
For Employer/Carrier

Before: Janice K. Bullard
Administrative Law Judge

DECISION AND ORDER

This proceeding arises from a claim for benefits under the Black Lung Act, 30 U.S.C. §§ 901-945 ("the Act") and the regulations issued thereunder, which are found in title 20 of the Code of Federal Regulations. Regulations referred to herein are contained in that Title.

Benefits under the Act are awarded to coal miners who are totally disabled within the meaning of the Act due to pneumoconiosis. Pneumoconiosis, commonly known as black lung, is a dust disease of the lungs resulting from coal dust inhalation.

On March 2, 2004, this case was referred to the Office of Administrative Law Judges for a formal hearing. DX 33.¹ Subsequently, this case was assigned to me. I held a formal hearing in Pikeville, Kentucky on May 11, 2005, at which time the parties had full opportunity to present evidence and argument. On June 26, and 27, 2005, Claimant and Employer respectively filed briefs. This decision is based upon consideration of the record and the arguments of the parties.

I. ISSUES

- (1) whether Claimant timely filed his claim for benefits;
- (2) whether Claimant has pneumoconiosis;
- (3) whether Claimant's pneumoconiosis arose out of coal mine employment; and
- (4) whether Claimant's disability is due to pneumoconiosis.²

II. FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Procedural Background

Branson Coleman, (hereinafter referred to as "Claimant") filed a claim for benefits under the Act on August 26, 2002. DX 2. On November 13, 2003, the District Director awarded benefits to Claimant. DX 26. In a letter dated November 18, 2003, Employer timely requested a formal hearing before the Office of Administrative Law Judges. DX 27.

B. Factual Background

Claimant was born on May 4, 1921 and is married to Gypsy Ann Coleman. TR at 12. Claimant testified that he was employed by Ike Coal Company, (hereinafter referred to as "Employer") at the time he last worked, in 1989. TR at 12. Claimant testified that at one time he had a small ownership interest in Ike Coal Company. TR at 22. Claimant stated that he was employed doing general coal mining work, such as "cleaning the dust up" Id. All of his work was performed underground. TR at 13. Claimant testified that he worked along conveyor belts that were approximately 1,000 feet long and that hauled coal out of the mine. TR. at 13. As part of his duties, Claimant would shovel coal and dust that had fallen back onto the conveyor belt. Tr. at 14. Claimant testified that he worked in a dusty environment. TR. at 15.

¹ In this Decision and Order, "DX" refers to Director's Exhibits; "CX" refers to Claimant's Exhibits; "EX" refers to Employer's Exhibits; "TR" refers to the Hearing Transcript; "EB" refers to Employer's Brief and "CB" refers to Claimant's Brief.

² Employer noted in its Brief that whether Claimant is disabled is not an issue in this matter. Rather, at issue is whether Claimant's disability is due to pneumoconiosis. See, EB at 2,4.

Before he worked along the beltline, Claimant helped prepare coal to be blasted from the mine. TR. at 16. Claimant used a crowbar or slate puller to remove loose rock from the top of the mine. TR at 14. In addition, Claimant worked as a roof bolter, which involved placing bolts in the roof of the mine to provide support for the mine. TR at 16-17. Claimant testified that the roof bolting work produced dust, which he inhaled. TR at 17. At the conclusion of his work shift, Claimant stated he would be “black and dirty.” TR. at 17. Claimant testified that occasionally he would cough up black material the day after working. TR. at 18.

Claimant testified that it was the responsibility of the section foreman or shift foreman to enter the mine and conduct a safety check before the other miners began work. TR at 23. Claimant stated that this was part of his job, but stated his son worked as the section foreman. TR 23-24. Claimant stated that he was responsible for ensuring the safety of the mine material. TR at 24. Claimant did not hold any certifications from the Department of Mines and Minerals but he had a mine foreman certificate from Kentucky, which he was required to take a test to obtain. Id.

Claimant began working in the coal mines in 1947, when he went to work for W & C Coal Company. TR at 18. While employed for W & C Coal Company, Claimant’s work involved hand loading coal, which he described as loading a car or buggy with coal using a coal shovel. Id. Claimant testified that he was paid based on the number of cars that were loaded. TR at 19. Claimant stopped working around July of 1989, because “the mine went broke.” TR at 19. Additionally, Claimant stated that “[a]ctually, I got to where I couldn’t hardly breathe then. You know, I’m going down. I didn’t try for anymore work anywhere else.” Id.

Claimant testified that he receives treatment for his breathing problems “very often.” Id. He stated that he has gone to the emergency room every two or three weeks and said that he is on oxygen “continually.” Id. Claimant stated he also has a breathing treatment machine at his home. Id. Claimant testified that he is currently being treated by Dr. Mettu for his breathing problems and that Dr. Mettu prescribed the oxygen for Claimant. TR at 20-21.

Claimant testified that he smoked a pack of cigarettes a week or a pack every couple of days. TR at 21. Claimant stated he stopped smoking over twenty years ago and that he quit before he stopped mining. Id. Claimant testified that he did not remember telling Dr. Mettu that he had smoked cigarettes and stated that he did not remember the doctor ever asking him about smoking. TR at 24. Claimant stated that he does not participate in any physically exertional activities because he doesn’t “have the oxygen and the strength to do it.” TR at 21-22.

Claimant testified that Dr. Mettu was the first doctor to diagnose him with black lung disease and estimated that he made the diagnosis at least three years ago. TR at 25. Claimant filed a state black lung claim in 1991 or 1992, and was awarded benefits. TR at 25-26. Claimant stated that he was awarded benefits based on the state black lung claim. TR at 26. To the best of his knowledge, he was diagnosed at that time with black lung disease, but Claimant could not remember specifically whether any physicians told him during this time that he was disabled by black lung. TR at 27.

C. Length of Coal Mine Employment

The District Director determined that Claimant established 27.5 years of coal mine employment. Both Employer and Claimant have agreed with this finding. TR at 6. I find that the record supports crediting Claimant with 27.5 years of coal mine employment.

D. Timeliness of Claimant's Claim for Benefits

The Act provides that, "[a]ny claim for benefits by a miner shall be filed within three years after . . . (1) a medical determination of total disability due to pneumoconiosis." 30 U.S.C. 932 (f). The regulations implementing the Act require that the determination of total disability due to pneumoconiosis is communicated to the miner or a person responsible for the miner's care. § 725.308 (a). Further, the regulations provide a "rebuttable presumption that every claim for benefits is timely filed." § 725.308 (c).

The Benefits Review Board ("the Board") addressed this limitations issue in Adkins v. Donaldson Coal Mines, 19 B.L.R. 1-36 (1993). First, the Board stated that "a 'medical determination' must be rendered by a physician, but may include . . . a state workers' compensation board finding based on medical conclusions" Id. at 1-41. The Board then stated that § 725.308 requires a written medical report that the administrative law judge finds is reasoned, documented and probative and which indicates total respiratory disability due to pneumoconiosis such that the claimant was aware of the total disability. Id. at 1-42. Further, the Board decided that the phrase "communicated to the miner" requires that the miner receives an actual written report that discloses the miner's disability due to pneumoconiosis. Id. at 1-43. The Board stated that an oral statement to the miner is not sufficient. Id.

Employer is arguing that Claimant did not file his claim for benefits within the required limitations period and that as a result, his claim should be denied. EB at 10-11. During the formal hearing, Claimant testified that Dr. Mettu was the first physician to diagnose him with pneumoconiosis. TR at 25. When asked how long ago that diagnosis was made, Claimant testified that it was made "[a]t least three years or longer." I find that Claimant's testimony is not sufficient to rebut the presumption that his claim was timely filed. Initially, I note that the statute of limitations does not begin to run until a medical determination of total disability due to pneumoconiosis is made. *See*, 30 U.S.C. 932 (f). A physician's diagnosis that a miner has pneumoconiosis is not tantamount to a determination that the miner is totally disabled as a result of the disease. The finding of pneumoconiosis and the finding that the claimant is disabled as a result of the disease are two separate elements a claimant must prove to be entitled to benefits under the Act. Claimant was not asked whether Dr. Mettu advised him that he was totally disabled. Rather, the question was "[d]o you recall when you were first diagnosed as having Black Lung Disease by a doctor?" TR at 25.³

³ Based on the wording of the question, I find Claimant may have interpreted the question to mean when from the date of the hearing was he first diagnosed with black lung disease. If that was Claimant's interpretation, then three years from the date of the hearing would have been May, 2002, which would have fallen within the applicable statute of limitations.

A review of the evidence reveals that Dr. Mettu prepared a report dated November 11, 2002 in which he opined that Claimant was totally disabled as a result of pneumoconiosis. DX 10. Without expressing an opinion as to the probative value of the opinion expressed in that report, I note that this report was authored after Claimant filed his claim for benefits. As a result, the statute of limitations would not apply.

Employer has also argued that the statute of limitations should apply to bar this claim as a result of Claimant's filing for state black lung benefits in 1991 or 1992. EB at 10. Claimant testified that he received state benefits based on black lung. TR at 26. Claimant testified that he received papers from an attorney, but stated that he does not remember whether they indicated he had black lung. Id. Further, Claimant testified that he was not sure if he received medical records that indicated he had black lung. TR at 26-27. Lastly, Claimant stated initially that he was not sure whether he was informed either orally or in writing that he was disabled as a result of black lung. However, in the same sentence he also stated, "I know they did." I find that this testimony is also insufficient to rebut the presumption that this claim was timely filed. Reviewing Claimant's testimony, I note that he was unable to provide a definitive answer to any of the questions. It is clear from his responses that Claimant does not recall the exact information he received. Employer has the burden of rebutting the presumption of timely filing of a claim. Other than Claimant's testimony, which is not entirely clear, Employer has not submitted any other evidence to rebut the presumption.

Contained in the Director's exhibits is a copy of Claimant's state black lung benefits compensation award dated July 29, 1992. DX 7. The award listed that Claimant was suffering from coal workers' pneumoconiosis. However, I note that the award does not indicate whether Claimant was totally disabled as a result of the disease. In Adkins, *supra*, the Board included a state workers' compensation board finding based on medical conclusions in the definition of a "medical determination." However, in reviewing the record, I note that there are no other documents regarding the state claim. Therefore, I am unable to determine how the state board based its determination of benefits. As a result, I am unable to make a determination pursuant to the Board's ruling in Adkins whether any medical reports relied upon by the state board were reasoned, documented and probative.

For these reasons, I find that Employer did not meet its burden of rebutting the presumption that this claim was timely filed.

E. Entitlement

Because this claim was filed after the enactment of the Part 718 regulations, Claimant's entitlement to benefits will be evaluated under Part 718 standards. In order to establish entitlement to benefits under Part 718, Claimant bears the burden of establishing the following elements by a preponderance of the evidence: (1) the miner suffers from pneumoconiosis, (2) the pneumoconiosis arose out of coal mine employment, (3) the miner is totally disabled, and (4) the miner's total disability is caused by pneumoconiosis. Director, OWCP v. Greenwich Colliers, 512 U.S. 267 (1994).

1. Presence of Pneumoconiosis

Section 718.201(a) defines pneumoconiosis as a “chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment” and “includes both medical, or ‘clinical,’ pneumoconiosis and statutory, or ‘legal,’ pneumoconiosis. Section 718.201 (a) (1) and (2) defines clinical pneumoconiosis and legal pneumoconiosis. Section 718.201 (b) states:

[A] disease “arising out of coal mine employment” includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

There are four means of establishing the existence of pneumoconiosis, set forth at § 718.202 (a)(1) through (a)(4).

- (1) x-ray evidence § 718.202 (a)
- (2) biopsy or autopsy evidence § 718.202 (a) (2)
- (3) regulatory presumptions § 718.202 (a)(3)
 - a) § 718.304 - Irrebuttable presumption of total disability due to pneumoconiosis if there is evidence of complicated pneumoconiosis.
 - b) § 718.305 - Where the claim was filed before January 1, 1982, there is a rebuttable presumption of total disability due to pneumoconiosis if the miner has proven fifteen (15) years of coal mine employment and there is other evidence demonstrating the existence of totally disabling respiratory or pulmonary impairment.
 - c) § 718.306 - Rebuttable presumption of entitlement applicable to cases where the miner died on or before March 1, 1978 and was employed in one of more coal mines prior to June 30, 1971.
- (4) Physician’s opinion based upon objective medical evidence §718.202 (a)(4).

a. Chest X-Ray Evidence

Under § 718.202(a)(1), the existence of pneumoconiosis can be established by chest x-rays conducted and classified in accordance with § 718.102.⁴ The current record contains the following chest x-ray evidence:

Date of x-ray	Date Read	Exhibit No.	Physician	Radiological Credentials	I.L.O. Classification
11/11/02	11/12/02	DX 10	A. Poulos	BCR; B	1/0
11/11/02	2/3/03	DX 12	C. Binns	BCR; B	0/1
11/11/02	3/14/05	CX 1	A. Ahmed	BCR; B	1/1
9/25/03	9/29/03	DX 13	G. Fino	B	0/0
9/25/03	11/20/03	CX 2	T. Miller	BCR; B	1/1

It is well established that the interpretation of an x-ray by a B- reader may be given additional weight by the fact-finder. Aimone v. Morrison Knudson Co., 8 B.L.R. 1-32, 1-34 (1985); Martin v. Director, OWCP, 6 B.L.R. 1-535, 1-537 (1983). The Benefits Review Board has also held that the interpretation of an x-ray by a physician who is a B-reader as well as a Board-certified radiologist may be given more weight than that of a physician who is only a B-reader. Scheckler v. Clinchfield Coal Co., 7 B.L.R. 1-128, 1-131 (1984). In addition, a judge is not required to accord greater weight to the most recent x-ray evidence of record, but rather, the length of time between the x-ray studies and the qualifications of the interpreting physicians are factors to be considered. McMath v. Director, OWCP, 12 B.L.R. 1-6 (1998); Pruitt v. Director, OWCP, 7 B.L.R. 1-544 (1984); Gleza v. Ohio Mining Co., 2 B.L.R. 1-436 (1979).

There are two chest x-rays in evidence in this matter. The film taken on November 11, 2002 was interpreted as positive for pneumoconiosis by Dr. Alex Poulos and Dr. Afzal Ahmed, who are both Board certified radiologists and B-readers. Dr. Carl Binns, who is also a Board certified radiologist and a B reader⁵ classified this film as 0/1. A chest x-ray classified under the category 0 does not constitute evidence of pneumoconiosis. § 718.102 (b). However, I note that on his report, Dr. Binns indicated there were abnormalities that were consistent with pneumoconiosis. DX 12. Based on my review of the evidence, I find that the evidence supports a finding that this x-ray is positive for the existence on pneumoconiosis.

The film taken on September 25, 2003 was interpreted as negative for pneumoconiosis by Dr. Gregory Fino, who is a B reader. Dr. Thomas Miller, who is a Board certified radiologist and a B reader, interpreted the September 25, 2003 film as positive for pneumoconiosis. I find that the opinion of Dr. Miller, as a board certified radiologist and B reader, is entitled to greater

⁴ A B-reader ("B") is a physician who has demonstrated a proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successful completion of an examination conducted by the United States Public Health Service. 42 C.F.R. § 37.51. A physician who is a Board certified radiologist ("BCR") has received certification in radiology of diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. 20 C.F.R. § 727.206(b)(2)(iii) (2001).

⁵ It should be noted that Dr. Binns' B-reader certificate, which was submitted into evidence as part of DX 12 expired on January 31, 1998. However, a check of the NIOSH Certified B-readers list online ([/niosh/topics/chestradiography/breader-list.html](http://niosh/topics/chestradiography/breader-list.html)) revealed that Dr. Scott is still designated as a B-reader.

weight than the opinion of Dr. Fino. Therefore, I find that this x-ray is also positive for the presence of pneumoconiosis.

Based on the foregoing, I find that the x-ray evidence supports a positive finding of pneumoconiosis.

b. Biopsy or autopsy evidence, § 718.202(a) (2)

A determination that pneumoconiosis is present may be based on a biopsy or autopsy. § 718.202(a) (2). That method is unavailable here because the current record contains no such evidence.

c. Regulatory Presumptions, § 718.202 (a) (3)

A determination of the existence of pneumoconiosis may also be made by using the presumptions described in §§ 718.304, 718.305 and 718.306. Section 718.304 requires x-ray biopsy or equivalent evidence of complicated pneumoconiosis, which is not present in this case. Section 718.305 is not applicable because this claim was filed after January 1, 1982. Section 718.306 is only applicable in the case of a deceased miner who died before March 1, 1978. Since none of these presumptions is applicable, the existence of pneumoconiosis has not been established under § 718.202 (a)(3).

d. Physicians' Opinions, § 718.202 (a) (4)

The fourth way to establish the existence of pneumoconiosis under § 718.202 is set forth as follows in subparagraph (a)(4):

A determination of the existence of pneumoconiosis may also be made if a physician exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

The record contains the following physicians' opinions.

Dr. RV Mettu

Dr. Mettu examined Claimant on behalf of the Department of Labor on November 11, 2002. DX. 10. Claimant's complaints at the time of his examination included cough, sputum, wheezing, dyspnea, orthopnea and paroxysmal nocturnal dyspnea. Id. Dr. Mettu noted that Claimant worked in the coal mines for thirty years. Additionally, Dr. Mettu noted that Claimant smoked one pack of cigarettes beginning at age 17 and ending twenty years ago. Id.

Dr. Mettu reviewed Claimant's chest x-ray taken by Dr. Poulos on November 11, 2002, which was interpreted as positive for pneumoconiosis. Additionally, Dr. Mettu reviewed the results of a ventilatory study he performed on the same date. Dr. Mettu diagnosed Claimant with chronic bronchitis and pneumoconiosis. DX 10. Dr. Mettu listed "working in coal mines" as the primary cause of Claimant's bronchitis and pneumoconiosis. Id. Further, Dr. Mettu stated that Claimant has a severe pulmonary impairment, which was caused by pneumoconiosis. Id. Dr. Mettu opined that Claimant was totally disabled as a result of his pulmonary impairment.

Claimant was treated by Dr. Mettu at Pikeville Medical Center on September 9, 2004 when he was admitted for complaints of severe shortness of breath, cough, chest congestion and chest tightness. CX 6 at 3. Dr. Mettu reported a history of end stage COPD and black lung. Id. Dr. Mettu's report indicated "Chest x-ray, verbal report was negative." Id. An arterial blood gas study produced results of a pH of 7.37, pCO₂ of 52, and a pO₂ of 91. Id.

Dr. Mettu also authored a letter dated April 14, 2005 in which he identified Claimant as his patient and stated that Claimant was totally disabled due to pneumoconiosis. CX 5.

Dr. Gregory J. Fino

Dr. Fino examined Claimant on September 25, 2003 and authored a report of that examination on October 9, 2003. DX 13. Claimant reported that he has had a breathing problem for 30 years and that it was getting worse. Id. Dr. Fino noted Claimant's complaints included dyspnea when walking, lifting or performing manual labor. Also, Claimant complained of chest pain, daily cough, mucous production and wheezing. Dr. Fino stated that Claimant "is limited in what he can do because of his breathing." Id. Dr. Fino listed a smoking history of one pack a day for forty (40) years. Id.

Dr. Fino reported that Claimant worked in the mining industry for 30 years and that he spent all of his employment underground. Id. Dr. Fino stated Claimant's last job in the mines was as a foreman, "which involved a lot of walking and crawling." The doctor also reported that Claimant "worked many other jobs in the mines." Id. Dr. Fino reported that Claimant left the mines due to retirement. Id.

Dr. Fino reported that he reviewed Dr. Mettu's report of his examination of Claimant on November 11, 2002. Additionally, he reviewed the results of the arterial blood gas and pulmonary function studies performed by Dr. Mettu along with the chest x-ray reading of November 11, 2002. Dr. Fino had a chest x-ray taken in conjunction with his examination of Claimant, which he classified as 0/0 and stated did not reveal pleural or parenchymal abnormalities consistent with pneumoconiosis. However, he noted changes related to emphysema. DX 13. Dr. Fino also administered a pulmonary function study, which he stated revealed "[s]evere obstruction with no bronchodilator response" as well as elevated lung volumes. Dr. Fino attributed these findings to cigarette smoking. Id. An arterial blood gas study performed by Dr. Fino revealed mild hypoxemia and normal oxygen saturation. Id.

Dr. Fino reported that Claimant has a disabling obstructive abnormality; however, he stated that he did not find any evidence that coal mine dust inhalation or coal workers' pneumoconiosis played a significant role in Claimant's abnormality. Dr. Fino concluded that Claimant has a disabling respiratory impairment, which precludes him from returning to his last job in the coal mine industry or any similar job. Id.

Dr. B. T. Westerfield

Dr. Westerfield authored a report dated January 20, 2004 based on his review of Claimant's medical records. EX 1. Dr. Westerfield reviewed the x-ray interpretations of Drs. Fino, Poulos, Binns and Barrett. In addition, he reviewed the reports of Dr. Fino and Dr. Mettu as well as the pulmonary function and arterial blood gas studies administered by these physicians. Dr. Westerfield stated that he did not personally examine Claimant and he did not have a chest x-ray that he could interpret. Id.

Based on his review of the medical evidence, Dr. Westerfield opined that Claimant did not suffer from pneumoconiosis. Id. Dr. Westerfield stated that Claimant suffers from Chronic Obstructive Pulmonary Disease; however, he opined that "inhalation of coal dust is very unlikely to have caused or contributed to [Claimant's] pulmonary disease." Id. Rather, Dr. Westerfield stated that "[t]he medical record implicates cigarette smoking as the most likely etiology of [Claimant's] Chronic Obstructive Pulmonary Disease." Id. Dr. Westerfield further opined that Claimant is totally disabled due to COPD, which he said was caused by smoking and not caused by exposure to coal dust. Id.

Dr. Westerfield also testified at a deposition on February 20, 2004. The transcript of that deposition was submitted into evidence as EX 2. Dr. Westerfield testified that he is Board certified in internal medicine and pulmonary medicine and stated that he specializes in occupational lung disease. EX 2 at 3. He also testified that he is a certified B reader. EX 2 at 4.

Dr. Westerfield testified that COPD is a group of lung disorders that cause airway obstruction and identified emphysema, chronic bronchitis and asthma as the three main forms of COPD. EX 2 at 9. Dr. Westerfield testified that asthma mostly has an allergic basis while chronic bronchitis and emphysema are primarily associated with smoking. EX 2 at 10. Dr. Westerfield testified that mineral inhalant can cause COPD, which is thought of as industrial bronchitis, and noted that this can be seen in coal miners. EX 2 at 10-11. He explained that a person's airways become overwhelmed with dust and "we develop hypertrophy, enlargement of the bronchial tubes, an increase in the mucus glands and mucus production, and we have symptoms of chronic bronchitis." EX 2 at 11. Further, Dr. Westerfield stated that with industrial bronchitis, "if the person is removed from the offending agent, then there's improvement and oftentimes hundred-percent regression in that injury to the lungs." Id. Dr. Westerfield testified that when coal miners "get away" from the mines, "they have improvement in that lung function related to inhaling coal dust." EX 2 at 12. When asked if there was any data to indicate that coal dust induced COPD would abate after a person is removed from mines, Dr. Westerfield stated "I think there is some epidemiological studies that show improvement from individuals who were working in coal mines and then when they're not working in coal mines." EX 2 at 13. Dr. Westerfield testified that a miner could also have a permanent COPD caused by coal dust

exposure. EX 2 at 25. Dr. Westerfield opined that the fact that Claimant's health has gotten worse after he stopped working in the coal mines supports the opinion that his abnormal respiratory function was not caused by coal dust. EX 2 at 42.

Dr. Westerfield testified that a physician is not able to distinguish the difference between COPD caused by the inhalation of coal dust or the inhalation of cigarette smoke based on a clinical examination of a patient. EX 2 at 11-12. However, Dr. Westerfield stated that statistically, cigarette smoking "causes much more impairment than coal dust in terms of COPD." EX 2 at 12. Dr. Westerfield explained that a person does not suffer as much injury to the lungs from coal dust as from cigarette smoke since "a lot of the coal dust is trapped in your upper airway" and as a result, "it doesn't actually get down in the lungs." EX 2 at 12-13. Additionally, he stated that "it's far more likely that injury from COPD is going to be from cigarettes rather than from coal dust." EX 2 at 13.

Dr. Westerfield testified that disabling COPD caused by cigarette smoking usually "shows x-ray changes that would be reflected in expansion of the lung fields, low, flat diaphragms, emphysema type changes in the upper lung fields." EX 2 at 14. Additionally, Dr. Westerfield stated "there will be thickening in the interstitial or bronchial markings which represent a thickening of the bronchial tubes from cigarette smoking." Id. Dr. Westerfield stated that he could not recall a medical study that showed COPD caused by coal dust that resulted in changes to an x-ray. EX 2 at 15.

Dr. Westerfield testified that he reviewed Dr. Fino's October 9, 2003 evaluation of Claimant and Dr. Mettu's November 11, 2002 respiratory evaluation. CX 2 at 15. Additionally, he reviewed the x-ray reports from Drs. Fino, Binns and Poulos. Id. Dr. Westerfield stated that Dr. Fino reported that Claimant was a heavy cigarette smoker and noted that Dr. Fino described decreased breath sounds on examination, which would be compatible with emphysema. CX 2 at 16. Dr. Westerfield testified that Dr. Fino found Claimant's x-ray negative for pneumoconiosis, but that he opined that Claimant had COPD present on the x-ray. CX 2 at 16. Dr. Westerfield opined that the COPD noted by Dr. Fino on the x-ray was related to cigarette smoking. Id. In support of his opinion that Claimant's COPD was caused by cigarette smoking, Dr. Westerfield relied upon Claimant's 40 pack years of smoking and the results of the pulmonary function tests that reveal "an emphysema type of respiratory function." EX 2 at 16-17.

Dr. Westerfield stated that Dr. Mettu made similar physical findings to those of Dr. Fino. EX 2 at 17. Dr. Westerfield noted that Dr. Mettu relied on an x-ray, which categorized Claimant's pneumoconiosis as 1/0. Id. Dr. Westerfield stated that the category 1/0 "is the least amount of pneumoconiosis on the ILO classification scale. 1/0 is barely black lung, if you want to think of it that way." EX 2 at 17-18. Dr. Westerfield testified that people with category 1 pneumoconiosis more often than not have no respiratory impairment. EX 2 at 18. Further, he testified that if an individual with category 1 pneumoconiosis has a respiratory impairment, "[i]t's certainly not disabling." EX 2 at 18.

Dr. Westerfield opined that Claimant is disabled; however, he stated that the disability is not due to pneumoconiosis. EX 2 at 19. Rather, Claimant's disability is due to emphysema related to cigarette smoking. Id. Dr. Westerfield testified that the spirometry test conducted by

Dr. Fino on September 25, 2003 reveals that Claimant is disabled. Id. Dr. Mettu's spirometry was found to be invalid by Dr. Westerfield because it did not meet the American Thoracic Society criteria. Id. Dr. Westerfield testified that the blood gas studies also produced results that are disabling. Id. Dr. Westerfield testified that the disability reflected by the pulmonary function and arterial blood gas studies was due to chronic obstructive lung disease resulting from cigarette smoking. EX 2 at 20.

Dr. Westerfield further testified that Claimant's pneumoconiosis level was at most 1/0, "which makes it less likely that inhalation of coal dust would cause this degree of respiratory dysfunction." Id. Dr. Westerfield stated that a person who has a respiratory dysfunction caused by inhaling coal dust will either have very little airway obstruction or the finding of pneumoconiosis will be greater than a Category 1. EX 2 at 22. The doctor further testified that disabling respiratory function, such as that exhibited by Claimant, is only seen in people with advanced black lung disease. EX 2 at 31. The doctor explained that COPD could be caused by a combination of factors, and said that he "can't rule out contribution from the coal dust." EX 2 at 26-27. However, Dr. Westerfield testified that his opinion remained that smoking caused Claimant's COPD. Id.

Dr. Westerfield believed that Claimant suffers from emphysema. EX 2 at 28. The doctor observed that there are different types of emphysema, and characterized emphysema caused by coal dust as focal emphysema, and emphysema caused by smoking as centrilobular emphysema. EX 2 at 29-30. Dr. Westerfield stated that focal emphysema can only be seen with a microscope, not on a chest x-ray. EX 2 at 30. Further, he stated that centrilobular emphysema is not caused by exposure to coal dust. Id. Dr. Westerfield also testified that the type of emphysema seen with smoking is referred to as panlobular, which is particularly in the upper lung zones, which is consistent with Claimant's test results. EX 2 at 40.

Dr. Westerfield testified that Dr. Binns' finding that Claimant's lungs were hyper-aerated indicated that emphysema was present, which is not consistent with an interpretation of the presence of pneumoconiosis. EX 2 at 34-35. Dr. Westerfield stated that Dr. Binns' finding of scarring with pleural thickening is not consistent with pneumoconiosis, but rather is associated with an old infection. EX 2 at 35-36. Dr. Binns' notation of linear scarring at the left lung base was most likely related to old pneumonia. Id. Dr. Westerfield observed that Dr. Binns noted the presence of small opacities, labeled "s" and "t", which are irregular in shape, and different from opacities associated with pneumoconiosis, which are more commonly round. Id. Dr. Westerfield explained that the ILO classification system allows a doctor interpreting an x-ray to recognize the presence of opacities and state that they may be consistent with pneumoconiosis. Id. However, he did find that the opacities "in no means are at a profusion category great enough to diagnose coal workers' pneumoconiosis." EX 2 at 37.

Dr. Elzer T. Fuller

Dr. Fuller treated Claimant when he was admitted to the Pikeville Medical Center on September 9, 2004. CX 6 at 1. Claimant complained of shortness of breath. Id. Dr. Fuller reported a history of COPD, congestive heart failure and paroxysmal atrial. Id. Dr. Fuller

reported that Claimant's chest was clear "with some scattered wheezes." A chest x-ray revealed COPD "with some chronic changes in the left base but nothing acute." *Id.*

Discussion

A medical opinion is well documented if it provides the clinical findings, observations, facts and other data the physician relied on to make a diagnosis. Fields v. Island Creek Coal Co., 10 B.L.R. 1-19 (1987). An opinion that is based on a physical examination, symptoms and a patient's work and social histories may be found to be adequately documented. Hoffman v. B & G Construction Co., 8 B.L.R. 1-65 (1985). A medical opinion is reasoned if the underlying documentation and data are adequate to support the findings of the physician. Fields, supra. A medical opinion that is unreasoned or undocumented may be given little or no weight. Clark v. Karst-Robbins Coal Co., 12 B.L.R. 1-149 (1989).

Following his review of Claimant's medical records, Dr. Westerfield concluded that Claimant did not have pneumoconiosis, but has COPD as the result of cigarette smoking. I find that Dr. Westerfield's opinion is entitled to reduced weight for several reasons. Dr. Westerfield did not examine Claimant, and based his opinion on his review of Claimant's medical records and the opinions of other physicians. I may give less weight to the report of a non-examining physician. Bogan v. Consolidation Coal Co., 6 BLR 1-1000, 1001-1002 (1984). Also, Dr. Westerfield's opinion is not fully consistent with the evidence. The doctor relied upon negative x-ray interpretations by Dr. Fino, which I have found merit less weight than the positive x-ray interpretation. Dr. Westerfield did not review Dr. Miller's x-ray interpretation, which I found is entitled to more weight than Dr. Fino's, and did not consider it in reaching his conclusion that Claimant does not have pneumoconiosis. Dr. Westerfield also relied on the earlier x-ray interpretation of Dr. Binns, which was negative for pneumoconiosis. Dr. Westerfield admitted that Dr. Binns noted that opacities consistent with pneumoconiosis were found, which he stated was permitted by the classification scheme, but the doctor concluded that the profusion of these opacities was not great enough to diagnose pneumoconiosis. Dr. Westerfield acknowledged that Dr. Poulos found this x-ray positive for pneumoconiosis, but stated that Dr. Poulos' classification of 1/0 barely represented black lung. I find that simply because Dr. Poulos classified the x-ray as showing the lowest level of pneumoconiosis is not a valid reason to disregard the positive finding. Dr. Westerfield offered no other reason for discounting the positive finding.

I further find that Dr. Westerfield's conclusion that Claimant's COPD was caused by cigarette smoking and not by coal mine dust inhalation is not well documented. Dr. Westerfield did not fully address and consider Claimant's history of coal mine employment in reaching his conclusion, although he did acknowledge that Claimant worked for 30 years in the underground coal industry. Dr. Westerfield was dismissive at best in his failure to consider Claimant's working conditions or the impact of his thirty years of coal mine employment on Claimant's breathing problems. Dr. Westerfield's opinion that Claimant's COPD is caused by cigarette smoking is detailed and reasoned, but the doctor did not explain how he eliminated a nearly 30 year coal mine employment history as a possible cause of Claimant's disease, particularly in light of x-rays that are positive for pneumoconiosis. Further, Dr. Westerfield's opinion was inconsistent in that, he admitted that coal mine dust could not be ruled out as a contributing factor in Claimant's pulmonary impairment. The regulations provide that pneumoconiosis

includes any “chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.” § 718.201 (a) (2). As a result of the foregoing, I find that Dr. Westerfield’s opinion that Claimant does not have pneumoconiosis is not well reasoned.

In his report dated November 11, 2002, Dr. Mettu reached the conclusion that Claimant was totally disabled as a result of pneumoconiosis brought on by his coal mine employment. He based his diagnosis on tests showing that Claimant has a severe pulmonary impairment and on an x-ray interpreted by Dr. Poulos as positive for pneumoconiosis. Although Dr. Mettu’s report did not provide any details regarding Claimant’s employment history, such as the type of work he performed or his working conditions, I note that Dr. Mettu has treated Claimant, and is familiar with his history. I find that Dr. Mettu’s opinion expressed in his November 11, 2002 report is the best documented and reasoned medical opinion of record regarding the existence of pneumoconiosis. Dr. Mettu considered the positive x-ray finding of Dr. Poulos, who is a Board certified radiologist and a B reader. I find that Dr. Mettu’s opinion is in accord with the overall analysis of the x-ray evidence. Further, Dr. Mettu considered a 30 year coal mine employment history. I find that Dr. Mettu’s opinion is supported by objective evidence, I accord it substantial weight on this issue.

Dr. Mettu’s September 9, 2004 report from Pikeville Medical Center stated that Claimant suffered from black lung. In the report, Dr. Mettu stated that Claimant was a “known patient.” CX 6 at 3. However, Dr. Mettu did not provide the foundation for his diagnosis of black lung. In his letter dated April 14, 2005, Dr. Mettu opined that Claimant is “totally and permanently disabled due to pneumoconiosis.” CX 5. However, again Dr. Mettu did not indicate what tests or examination he relied upon to reach his conclusion. As a result, I find that the September 9, 2004 and the April 14, 2005 letters from Dr. Mettu are conclusory and entitled to little weight on the issue of whether Claimant has pneumoconiosis.

Dr. Fino concluded that there was “insufficient medical evidence to justify a diagnosis of clinical or legal pneumoconiosis.” DX 13. The doctor interpreted a chest x-ray performed in conjunction with his examination of Claimant as negative for pneumoconiosis. Although Dr. Fino stated that he received readings of the November 11, 2002 x-ray, his report did not indicate whether he reviewed these readings. His report fails to address the findings of Drs. Poulos and Binns. For these reasons, I find that Dr. Fino’s opinion is not well-documented, and is entitled to less weight.

I further find that Dr. Fino’s opinion is not well-reasoned. He attributed Claimant’s disabling respiratory condition to his smoking history, and concluded that coal mine dust would have insignificantly contributed to Claimant’s pulmonary obstruction. Although Dr. Fino noted a 30 year coal mine employment history, he did not explain why he dismissed those 30 years as an insignificant contributor to Claimant’s disease. Dr. Fino stated that Claimant last worked as a foreman in the mines, and observed that this job involved “a lot of crawling and walking.” However, the doctor did not address the actual work performed by Claimant in the mines. I find that Dr. Fino’s failure to adequately address Claimant’s work in the mines does not support his conclusion that exposure to mine dust would have been an insignificant contributor to Claimant’s disease. Therefore, I find Dr. Fino’s opinion that Claimant did not suffer from pneumoconiosis is not entitled to any probative value.

Considering the physician opinion evidence as a whole, I find that it demonstrates that Claimant has pneumoconiosis. Considering all of the evidence together I find that it established that Claimant has pneumoconiosis.

2. Pneumoconiosis arose out of coal mine employment

Based on Claimant's 27.5 years of coal mine employment history, he is entitled to a rebuttable presumption that pneumoconiosis arose out of his coal mine employment. § 718.203 (b). No evidence has been presented to rebut the presumption, and accordingly, I find that Claimant's pneumoconiosis arose out of coal mine employment.

3. Claimant is totally disabled

In order for Claimant to prevail, he must establish that he is totally disabled due to a respiratory or pulmonary condition. Total disability is defined in § 718.204 (b) (1) as follows:

A miner shall be considered totally disabled if the miner has a pulmonary or respiratory impairment which, standing alone prevents or prevented the miner (i) [f]rom performing his or her usual coal mine work; and (ii) [f]rom engaging in [other] gainful employment in a mine or mines.

§ 718.204(b)(1). Non-pulmonary and non-respiratory conditions, which cause an "independent disability unrelated to the miner's pulmonary or respiratory disability" have no bearing on total disability under the Act. § 718.204(a). Additionally, § 718.204(a) provides that:

If, however, a non-pulmonary or non-respiratory condition or disease causes a chronic respiratory or pulmonary impairment, that condition shall be considered in determining whether the miner is or was totally disabled [under the Act].

Employer has stipulated that Claimant is totally disabled as a result of a respiratory disease. EB 4. I find that the objective evidence of record supports this conclusion.

4. Total disability due to pneumoconiosis

Claimant bears the burden of proving that pneumoconiosis is a substantial contributor to his total respiratory disability. § 718.204 (c) (1). Sections 718.204 (c) (1) (i) and (ii) provide that pneumoconiosis is a "substantially contributing cause" of the miner's disability if it:

- (i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or
- (ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment.

§ 718.204 (c) (1) (i), (ii). Disability due to pneumoconiosis may be established by a documented and reasoned medical report. § 718.204 (c) (2).

The evidence regarding the causation of Claimant's disability includes the opinions of Drs. Mettu, Fino and Westerfield. Initially, I note that the opinions of Dr. Fino and Dr. Westerfield may be discounted since both doctors determined that Claimant did not suffer from either clinical or legal pneumoconiosis. Further, I reject the opinion of Dr. Westerfield because I find that it is hostile to the Act. A medical opinion can be rejected as hostile to the Act if it forecloses any possibility that simple pneumoconiosis can be disabling. Searls v. Southern Ohio Coal Co., 11 B.L.R. 1-161, 1-164 (1988). In his deposition testimony, Dr. Westerfield stated if an individual with category 1 pneumoconiosis has a respiratory impairment, "[i]t's certainly not disabling." EX. 2 at 18. I find that Dr. Westerfield's opinion is hostile to the Act because it forecloses the possibility that category 1 pneumoconiosis could be disabling.

Dr. Mettu opined that Claimant's disability was caused by pneumoconiosis. However, Dr. Mettu did not thoroughly account for Claimant's smoking history in reaching his conclusion that Claimant was disabled. Dr. Mettu's opinion was based on the positive x-ray interpretation of Dr. Poulos along with Claimant's coal mine employment history. He reported that Claimant suffered from a severe pulmonary impairment, but did not indicate how he was able to reason that Claimant's disability was related solely to pneumoconiosis. Dr. Mettu noted that Claimant had a thirty year history of coal mine employment. Dr. Mettu also noted that Claimant smoked one pack of cigarettes a day from the time he was 17 until twenty years before the exam, which would have been when Claimant was approximately 61 years old. However, Dr. Mettu did not indicate whether this smoking history was considered when he opined that Claimant suffered from pneumoconiosis. Dr. Mettu did not address whether Claimant's smoking would have affected his respiratory condition. This failure detracts from the probative value of Dr. Mettu's report, and I am unable to accord it substantial weight.

I find that the medical opinion evidence establishes that Claimant is disabled from a pulmonary condition. However, I find that the evidence does not demonstrate that Claimant's disability is due to pneumoconiosis.

III. CONCLUSION

Based on my review of the evidence, I find that Claimant has failed to establish that he is disabled due to pneumoconiosis.

ATTORNEY'S FEE

The award of an attorney's fee is permitted only in cases in which the Claimant is found to be entitled to benefits under the Act. Since benefits are not awarded in this claim, the Act prohibits the charging of any fee to Claimant for representation services rendered in pursuit of his claim.

ORDER

The claim of Branson Coleman for benefits under the Act is hereby DENIED.

A

Janice K. Bullard
Administrative Law Judge

Cherry Hill, New Jersey

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of the Decision and Order by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601. A copy of the Notice of Appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.